Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Filing at a Glance

Company: Amalgamated Life Insurance Company

Product Name: Workers Life Plus SERFF Tr Num: AMAL-126333212 State: Arkansas TOI: L04G Group Life - Term SERFF Status: Closed-Approved-State Tr Num: 44099

Closed

Sub-TOI: L04G.313 Decreasing - Single Life - Co Tr Num: ALGDTP-09 State Status: Approved-Closed

Fixed/Indeterminate Premium

Filing Type: Form Reviewer(s): Linda Bird

Author: Claire Pizzuti Disposition Date: 11/20/2009
Date Submitted: 11/16/2009 Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Workers Life Plus Status of Filing in Domicile: Authorized Project Number: ALGDTP-09 Date Approved in Domicile: 12/22/1994

Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large

Overall Rate Impact: Group Market Type: Employer, Association,

Other

Filing Status Changed: 11/20/2009 Explanation for Other Group Market Type:

Union

State Status Changed: 11/20/2009

Deemer Date: Created By: Claire Pizzuti

Submitted By: Claire Pizzuti Corresponding Filing Tracking Number:

Filing Description:

Form ALGDTP-09, Group Term Life Insurance Policy, provides term insurance protection to individuals eligible to be insured under the group policy. The policy allows for both decreasing and level term coverage. Form ALGDTP-END-09, Endorsement, is attached to the policy to allow for level term coverage.

Form ALGDTC-09, Group Decreasing Term Insurance Certificate, is provided to the individual insured as evidence of

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

decreasing term coverage under the group policy. Form ALGLTC-09, Group Level Term Insurance Certificate, is provided to the individual insured as evidence of level term coverage. Dependent coverage is available under either certificate. The type of term coverage, level or decreasing, is selected at the group policy level. Only one term coverage type per insured is permitted. The product is voluntary and paid entirely by the individual certificate holder through payroll deduction or similar billing procedures.

Bracketed text indicates variability dependent primarily upon the type of group to which the policy is issued and the insured benefits selected. When the variable is a numerical range within brackets, any number selected would be chosen from within the specified range. When several alternatives are specified within a bracket, any alternative selected would be one of the alternatives specified within bracket unless indicated otherwise.

Form ALGDTEF-09 (AR), Enrollment form, will be used to apply for decreasing term coverage. Form ALGLTEF-09 (AR), Enrollment Form, will be used to apply for level term coverage. Form ALGA-09, Group Policy Application is completed by the group policy holder.

The following optional benefit riders are available for use with this group life policy and any other group term life products that may be approved in the future.

Form ALTLADBR-09 is an Accidental Death Benefit Rider. It provides for an additional death benefit if death is caused by an accident.

Form ALTLLBRC-07 is a Living Benefit Rider. It provides for the accelerated payment of a portion of the scheduled death benefit in effect upon diagnosis of a terminal illness or covered critical illness. The death benefit may be accelerated for the insured, a covered spouse, or a covered dependent child. Only one accelerated benefit payment per coverage person is allowed. Additionally, the rider provides for a Hospitalization Benefit (upon or thirty consecutive days of medically necessary hospital confinement) and a Restoration of Group Term Benefit which reinstates the accelerated portion of the insured's death benefit upon certain conditions outlined in the Rider. These benefits are optional at the group or policy level. The Restoration Benefit is available only to the insured. It is not available to covered dependents. There is a separate premium payment for this particular Rider. There are no cash values associated with this Rider.

Also enclosed are the related claim form (AMADB-AD-PLUS-01(FW), disclosure form (AMADBDIS-PLUS-01) and generic illustration (AMADBDIS2-PLUS-01) associated with the use of this accelerated benefit rider.

This policy is intended to be marketed primarily to members of labor unions and labor organizations, to associations and traditional employer groups. This marketing will be conducted in the workplace.

The forms have been completed in John Doe fashion and are subject to minor modification in paper size and stock, ink,

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09 logo, border and adaptation to electronic printing.

Company and Contact

Filing Contact Information

Claire Pizzuti, Policy Form Compliance cpizzuti@amalgamatedlife.com

Manager

 333 Westchester Avenue
 914-367-5581 [Phone]

 White Plains, NY 10604
 914-367-4115 [FAX]

Filing Company Information

Amalgamated Life Insurance Company CoCode: 60216 State of Domicile: New York

333 Westchester Ave. Group Code: Company Type: White Plains, NY 10604 Group Name: State ID Number:

(914) 367-5581 ext. [Phone] FEIN Number: 13-5501223

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No

Fee Explanation: One policy and associated forms @ \$50 per policy form.

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Amalgamated Life Insurance Company \$50.00 11/16/2009 32068107

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Correspondence Summary

Dispositions

Status Created By Created On Date Submitted

Approved- Linda Bird 11/20/2009 11/20/2009

Closed

Objection Letters and Response Letters

Objection Letters Response Letters Status Created By Created On Date Submitted **Responded By Date Submitted Created On** Linda Bird Claire Pizzuti Pending 11/20/2009 11/20/2009 11/20/2009 11/20/2009 Industry Response

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Disposition

Disposition Date: 11/20/2009

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

 SERFF Tracking Number:
 AMAL-126333212
 State:
 Arkansas

 Filing Company:
 Amalgamated Life Insurance Company
 State Tracking Number:
 44099

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Schedule	Schedule Item	Schedule Item Status Public Access
Supporting Document	Flesch Certification	Yes
Supporting Document	Application	Yes
Supporting Document	Actuarial memo for policy	No
Supporting Document	Actuarial memo for rider	No
Supporting Document	Claim form, etc. for living benefit rider	Yes
Form	Group Term Life Insurance Policy	Yes
Form	Group Decreasing Term Insurance	Yes
	Certificate	
Form	Group Level Term Life Insurance	Yes
	Certificate	
Form	Group Level Term Endorsement	Yes
Form	Living Benefit Rider	Yes
Form	Accidental Death Benefit Rider	Yes

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/20/2009
Submitted Date 11/20/2009
Respond By Date 12/21/2009

Dear Claire Pizzuti,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the providions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Response Letter

Response Letter Status Submitted to State

Response Letter Date 11/20/2009 Submitted Date 11/20/2009

Dear Linda Bird,

Comments:

Following is our response to your objection.

Response 1

Comments: We have a form that will be used to address the requirements of Bulletin 15-2009.

In addition, per Regulation 19s10B, we certify that the policy forms included in this filing do not discriminate based on the gender of the applicant.

Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue. Please review your issue procedures and assure us that you are in compliance with Ark. Code Ann. 23-79-138.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the providions of this rule as well as all applicable requirements of this Department.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any further questions on this matter, please let me know. We look forward to your approval of these forms in the near future.

SERFF Tracking Number: AMAL-126333212 State: Arkansas

Filing Company: Amalgamated Life Insurance Company State Tracking Number: 44099

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Sincerely, Claire Pizzuti

 SERFF Tracking Number:
 AMAL-126333212
 State:
 Arkansas

 Filing Company:
 Amalgamated Life Insurance Company
 State Tracking Number:
 44099

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Form Schedule

Lead Form Number: ALGDTP-09

Schedule Item Status	Form Number	Form Type	e Form Name	Action	Action Specific Data	Readability	Attachment
	ALGDTP- 09	•	t Group Term Life n Insurance Policy	Initial		49.000	ALGDTP-09 Group Term Policy.pdf
	ALGDTC- 09	Certificate	Group Decreasing Term Insurance Certificate	Initial		62.400	ALGDTC-09 Decreasing Term Certificate.pdf
	ALGLTC- 09	Certificate	Group Level Term Life Insurance Certificate	Initial		62.000	ALGLTC-09 Level Term Certificate.pdf
	ALGDTP- END-09	•	ו	Initial		46.600	ALGDTP- END-09 Endorsement. pdf
	ALTLLBRC -07	C Certificate Amendmer t, Insert Page, Endorsement or Rider		Initial		46.100	ALTLLBRC- 07 Living Benefit Rider.pdf
	ALTLADBF -09		Accidental Death Benefit Rider	Initial		55.900	ALTLADBR- 09 - Accidental Death Benefit

SERFF Tracking Number: AMAL-126333212 State: Arkansas

Filing Company: Amalgamated Life Insurance Company State Tracking Number: 44099

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Endorseme Rider.pdf

nt or Rider

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604 Telephone: 1-800 315 9178

GROUP POLICYHOLDER [Union ABC]

GROUP POLICY NUMBER [123]

EFFECTIVE DATE [January 1, 2009]

We agree to pay the benefits shown in the Certificate Schedule of Insurance shown in the Policy Schedule and in the certificates of insurance attached to this Policy, subject to the provisions of this policy. This Policy and the Application for this Policy, a copy of which is attached, and the attached certificates and riders make up the entire contract between you and us. A Certificate of Insurance will be issued to each enrolled Certificate Holder which describes the policy as it applies to him or her.

Signed for Amalgamated Life Insurance Company on the Date of Issue.

David J. Walsh President

Group Term Life Insurance
Policy
Non-Participating

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POLICY SCHEDULE

GROUP POLICYHOLDER [Union ABC]

GROUP POLICY NUMBER [123]

EFFECTIVE DATE [January 1, 2009]

 Persons eligible to become Certificate Holders under the policy are those who fall within the classes described below:

CLASS DESCRIPTION OF ELIGIBLE PERSONS

- [II [Your employees who have not reached the age at which the benefit in the Schedule-Certificate Holder is zero. On the day a person enrolls for insurance under this policy, he or she must be at least age 16 and not over age 65 and actively at work. A person may not enroll if he or she is an Insured Dependent under this policy.]
- Persons eligible to become Insured Dependents under the policy are those who fall within the classes described below:

CLASS DESCRIPTION OF ELIGIBLE PERSONS

[Spouse] [The legal spouse of a

[The legal spouse of a Certificate Holder, if the spouse has not reached the age at which the Benefit in the Schedule - Dependents is zero. On the day the spouse is enrolled by the Certificate Holder, the spouse must be at least age 16 and not over age 65. A spouse is not eligible if the spouse is a Certificate Holder under this policy.]

[Children]

[The natural or legally adopted child of a Certificate Holder, if the child has not reached the age at which the Benefit in the Schedule - Dependents is zero. A child is not eligible if he or she is a Certificate Holder under this policy. A child may not be an Insured Dependent under more than one Certificate under this policy.]

POLICY SCHEDULE (continued)

3. Certificates form(s) and riders which are a part of this policy, and applicable premium rates are:

FORM PREMIUM

ALGDTC-09

[\$2.00 per week per Certificate Holder, plus \$0.45 per week for each Certificate with Spouse enrolled, plus \$0.20 per week for each Certificate with Children enrolled.]

DEFINITIONS

"We", "us", "our" and "Company" means Amalgamated Life Insurance Company at our Home Office at 333 Westchester Avenue, White Plains, NY 10604.

"You", "your" means the Group Policyholder shown on the Policy Schedule.

ENROLLMENT

To become insured, a person eligible to become a Certificate Holder must complete and sign an enrollment form for submission to us. We will furnish enrollment forms directly or through you. The completed forms must be submitted to us directly or through you.

An enrollment form may request insurance for the Certificate Holder's spouse and/or children. Insurance must be in force on the Certificate Holder and the spouse and/or children must be eligible persons in order for insurance on spouse or children to be in force.

A new enrollment form does not have to be submitted for a natural child or a Certificate Holder who is born alive while any child of the Certificate Holder is an Insured Dependent. The new child will be an Insured Dependent. A new enrollment form must be submitted if newly adopted children are to be insured.

If a person eligible to become a Certificate Holder submits a properly completed enrollment form within 31 days after becoming an eligible person, we will issue a Certificate of Insurance on one of the forms listed in the Policy Schedule. The Certificate Holder's Insured Dependents may be insured if requested on the enrollment form.

The enrollment form may ask questions about the health of persons to be insured. If a person who wants to be a Certificate Holder submits an enrollment form more than 31 days after becoming an eligible person, we may refuse to insure the person based on his or her health. If spouse and/or children are enrolled more than 31 days after Certificate Holder became an eligible person, we may refuse to insure one or more of them based on their health.

WHEN INSURANCE BEGINS

For insurance to begin, we must receive a properly completed enrollment form and all other requirements must be met. Insurance under the Certificate of Insurance will take effect when we receive the enrollment form, unless we refuse to insure the relevant person in accordance with the Enrollment provision.

PREMIUMS

The premium due on and after the Effective Date of this policy will be computed in accordance with the rates shown in the Policy Schedule. You may deduct all or part of the premium for a certificate from the Certificate Holder's pay. A Certificate of Insurance will not be issued unless the Certificate Holder authorizes such deduction in a way satisfactory to you. No insurance on Insured Dependents will take effect unless the Certificate Holder authorizes the required deduction.

You will remit premiums to us at the frequency shown in the Policy Schedule.

EXPERIENCE CREDIT

This policy does not share in our earnings. No dividends are payable.

At the end of each policy year, we may allow you an experience credit. Such credit will be based on an experience rating plan we are then using. It will be paid to you unless you request it be applied to reduce any future premium payment.

The total of any experience credit may be in excess of the difference between (a) the total premiums for this policy and (b) the amounts paid by Certificate Holders. if so, the excess shall be applied by you for the sole benefit of the [Certificate Holders] [your employees] [participants in the trust]. We are not obliged to see that such excess is properly applied.

INCONTESTABILITY

This policy will not be contested after it has been in force for two years from its Effective Date, except for failure to pay premiums.

Any statement by you, a Certificate Holder or an Insured Dependent will be deemed a representation and not a warranty. No statement may be used to defend against a claim or to deny a claim under it, unless the statement is contained in the written application and/or enrollment form.

ASSIGNMENT

We will not be bound by any assignment of this policy by you or of any Certificate of Life Insurance under the policy by any Certificate Holder unless:

- (a) it is in writing,
- (b) it has been received by us, and
- (c) it has been approved by us in writing.

We will not be responsible for the validity of any assignment.

CHANGES IN POLICY

The provisions of the Policy may be changed only if the change is agreed to in writing and signed by one of our officers.

We may change premiums and/or schedules of benefits, but not with respect to persons insured prior to the change as long as this policy and any relevant Certificate of Life Insurance are continuously in force.

TERMINATION OF POLICY

This policy and all insurance will terminate at the earlier of:

- (a) 91 days from the last day of the last period for which we receive premiums from you, or
- (b) 91 days from receipt by you or us from the other of written notice of intention to cancel the policy. If the policy is terminated as stated, premiums will be due for the 91 day period.

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604 Telephone: 1-800 315 9178

> Group Term Life Insurance Policy Non-Participating

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604
Telephone: 1-800 315 9178

CERTIFICATE HOLDER [John Doe]

CERTIFICATE NUMBER [Specimen 123]

GROUP POLICY NUMBER [123]

POLICYHOLDER [Union ABC]

This is to certify that, subject to the terms of the above Group Policy, you are insured for the benefits as shown in the Schedule and described in this certificate.

Insurance takes effect only if you are eligible for it, you elect it and you make contribution for it as required.

This certificate takes the place of any prior one issued to you by us covering the insurance. It is not the insurance contract. The insurance contract is held by the Group Policyholder. You may request to inspect it at the Policyholder's main office during usual business hours. **READ YOUR CERTIFICATE CAREFULLY**

Signed for Amalgamated Life Insurance Company on the Date of Issue.

David J. Walsh

President

Group Decreasing Term Life Insurance
Certificate
Non-Participating

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SCHEDULE OF INSURANCE

CERTIFICATE HOLDER [John Doe]

DATE OF BIRTH [xx/xx/xxxx]

CERTIFICATE NUMBER [Specimen 123]

GROUP POLICY NUMBER [123]

GROUP POLICYHOLDER [Union ABC]

CERTIFICATE EFFECTIVE DATE [2/1/2009]

BENEFICIARY [Mary Doe, Wife]

INSURED DEPENDENTS

[Mary Doe, Wife] DATE OF BIRTH [1/1/79] Age [30]

[Lucy Doe, Child] DATE OF BIRTH [1/10/07]

Limiting Age [21]

WEEKLY PREMIUM [\$XX.XX]

SCHEDULE OF BENEFITS PER UNIT

Age		Age		Age	
at Death	Benefit	at Deatl	n Benefit	at Death	Benefit
-		41	\$45,000	56	\$12,000
Under		42	45,000	57	12,000
30	\$75,000	43	45,000	58	12,000
		44	45,000	59	12,000
30	75,000	45	30,000	60	7,000
31	75,000	46	30,000	61	7,000
32	75,000	47	30,000	62	7,000
33	75,000	48	30,000	63	7,000
34	75,000	49	30,000	64	7,000
35	60,000	50	20,000	65 or more	0
36	60,000	51	20,000		
37	60,000	52	20,000		
38	60,000	53	20,000		
39	60,000	54	20,000		
40	45,000	55	12,000		
			•		

SCHEDULE OF BENEFITS PER UNIT

WEEKLY PREMIUM [\$XX.XXX]

SCHEDULE OF DEPENDENT BENEFITS PER UNIT - SPOUSE (if insured)

Age		Age		Age	
at Death	Benefit	at Death	Benefi	at Death	Benefi
		41	\$4,500	56	\$1,200
Under		42	4,500	57	1,200
30	\$7,500	43	4,500	58	1,200
		44	4,500	59	1,200
30	7,500	45	3,000	60	700
31	7,500	46	3,000	61	700
32	7,500	47	3,000	62	700
33	7,500	48	3,000	63	700
34	7,500	49	3,000	64	700
35	6,000	50	2,000	65 or more	0
36	6,000	51	2,000		
37	6,000	52	2,000		
38	6,000	53	2,000		
39	6,000	54	2,000		
40	4,500	55	1,200		

WEEKLY PREMIUM [\$XX.XX]

SCHEDULE OF DEPENDENT BENEFITS PER UNIT - CHILDREN (if insured)

Age at death	Benefit
Live birth through 5 months	\$500
6 months through age 21	\$4,000
Age 23 or more	0

DEFINITIONS

"We", **"us"**, "our" and "Company" means Amalgamated Life Insurance Company at our Home Office at 333 Westchester Avenue, White Plains, NY 10604.

"You", "your" means the Certificate Holder shown in the Schedule of Insurance.

"Policyholder" means the Group Policyholder shown in the Policy Schedule.

"Laid off" means you are not working because your employer has stopped providing work for you, and you are not being paid by any employer.

Disabled" means you are not working and are not able to do work of any. kind for wage or profit.

"Age" means the number of whole years since birth, or number of whole months for children less than 3 year. Age at the beginning of the year means age of the person insured on January 1 of the calendar year.

DEATH BENEFIT

If you die while this Certificate is in force, we will pay the Death Benefit to the Beneficiary, subject to the terms of the group policy. We must receive due proof of your death at our Home Office. The amount of the Death Benefit is shown in the Schedule of Insurance. It is based on your age when you die.

If an Insured Dependent dies while insured under this Certificate, we will pay the Death Benefit to you, subject to the terms of the group policy. We must receive due proof of death at our Home Office. The amount of the Death Benefit is shown on the Schedule of Insurance. It is based on the age of your dependent at death.

MISSTATEMENT OF AGE

If the age or date of birth of an insured person shown in the Schedule of Insurance is not right, the Benefit paid at death will be based on the correct age or date of birth of such insured. If the benefit based on the correct age is zero, a refund of premium will be made. The amount of the refund will be the premiums paid to us since the benefit became zero.

INSURED DEPENDENT

For your spouse to be an Insured Dependent, we must have received a completed Enrollment Form signed by you that asks for insurance for your spouse. For your natural or legally adopted child to bean Insured Dependent, we must have received a completed Enrollment Form signed by you that asks for insurance for your children.

For a person to be an Insured Dependent at any time:

- (a) he or she must be an eligible dependent under the terms of the group policy,
- (b) you must not have revoked your payroll deduction authorization, and
- (c) you must still be insured under this Certificate.

You may enroll your dependents at any time, subject to the terms of the group policy. We may ask questions about their health when you enroll them, and we may refuse to insure one or more of them based on their health. You do not have to submit a new Enrollment Form for your natural child who is born alive while any of your children is an Insured Dependent. The new child will be an Insured Dependent at no extra cost if the above conditions are met. You do have to submit a new Enrollment Form for your newly adopted children if you want them to be Insured Dependents.

BENEFICIARY

The Beneficiary is the person to whom the death benefit is payable upon your death. The Beneficiary is named in the Enrollment Form for this insurance. You may change the Beneficiary at any time. You must do this in writing and you must date and sign the form. The change will take effect when we receive it.

If you name more than one Beneficiary, the Beneficiaries who survive you will receive the Benefit in equal shares unless you specify other shares. If no Beneficiary is alive when you die, the Benefit will be paid to the surviving person or persons first named in these classes:

- (a) your spouse;
- (b) your children, equally;
- (c) your parents, equally;
- (d) your brothers and sisters, equally;
- (e) your estate.

WHEN YOUR INSURANCE ENDS

Except as provided under Conversion, your insurance under this Certificate will end at the earlier of:

- (a) if you are laid off or disabled, [91 days] from the last day you worked;
- (b) if you are no longer employed by the Group Policyholder, and are not laid off or disabled, [31 days from] the last day you worked;
- (c) if you cancel your insurance by revoking your payroll deduction authorization, [31 days from] the end of the last payroll period for which deductions were made;
- (d) if premiums are not sent to us by the Group Policyholder, [31 days] from the last day of the last pay period for which we received premiums;
- (e) if you die, the date of your death;
- (f) if the group policy terminates, on the day the group policy terminates.

You do not have to pay premiums while you are laid off or disabled.

CONVERSION

You may buy a new policy if your insurance ends because

- (a) you are no longer employed by the Group Policyholder, or
- (b) because the group policy terminates.

The new policy may be on your life, but you may also buy a new policy on each of your Insured Dependents. Your spouse may buy a new policy if you die or if your marriage ends by divorce or annulment. It may be on his or her life if he or she was an Insured Dependent, but a new policy may also be bought on each child who was an Insured Dependent. Each child who is an Insured Dependent may buy a new policy on his or her life if the child's insurance ends when the child reaches the limiting age shown in the Schedule of Insurance.

Each new policy will provide life insurance only. It will be on one of the forms, other than term insurance, usually issued by us to individuals. The person who buys the converted policy may choose to have it preceded by term insurance for not more than one year with premiums payable at the same frequency as for the converted policy. The amount of insurance will be not less than \$500 and not more than the Benefit for the person under this certificate when *your* insurance ended. The premium for the new policy will be at our usual rates for the class of risk to which the person belongs.

You may buy a new policy on your life if the following conditions are met:

- (a) you are over age 60
- (b) the reduction in the benefit amount exceeds 20% of the initial benefit amount. The initial amount is the amount of benefit at the later of your age 60, or your age when this certificate was issued. The reduction amount is the difference between the initial amount and your current benefit.

The amount of insurance may not exceed the reduction amount.

To exercise the right to convert, a person must submit to us an application for a new policy and pay the first premium. If the person is notified of the right to convert within 15 days before or after the event that creates the right to convert, this must be done within 31 days of the event. Then the new policy will take effect 31 days after the event. If the person is not notified in that period, the time to apply to us is extended to the earlier of 45 days after notice is given or 90 days after the event. Then the new policy will take effect on the later of 31 days after the event or when the first premium is paid. If the person on whose life insurance may be purchased dies within 31 days after the event, we will pay, in accord with the terms of this policy, the amount of life insurance that could have been converted.

THE CONTRACT

This Certificate is not a contract. It is a statement of the coverage provided by the Group Policy. The provisions of the Group Policy that apply to you are shown in this Certificate. The entire contract is made up of the policy, the application for the policy, the certificate of insurance, any enrollment form completed by you or an insured dependent, copies of which are attached. Statements made by you or any insured dependent will be deemed representations and not warranties. No statement may be used to defend against a claim or to deny a claim under it, unless the statement is contained in the written application and/or enrollment form.

No one can change the terms of the contract unless the change is agreed to in writing and signed by one of our officers. Once a person is insured under this Certificate, the premium and the Schedule for that person will not be changed as long as the group insurance policy and this certificate are continuously in force.

INCONTESTABILITY

Statements you make about any person insured under this Certificate will not be used to contest the insurance on that person:

- (a) unless it is in writing and a copy is given to you or your Beneficiary, or
- (b) after insurance on the person has been in effect for two years during the life of that person.

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604 Telephone: 1-800 315 9178

Endorsements, If any

Group Decreasing Term Life Insurance
Certificate
Non-Participating

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604 Telephone: 1-800 315 9178

CERTIFICATE HOLDER [John Doe]

CERTIFICATE NUMBER [Specimen 123]

GROUP POLICY NUMBER [123]

POLICYHOLDER [Union ABC]

This is to certify that, subject to the terms of the above Group Policy, you are insured for the benefits as shown in the Schedule and described in this certificate.

Insurance takes effect only if you are eligible for it, you elect it and you make contribution for it as required.

This certificate takes the place of any prior one issued to you by us covering the insurance. It is not the insurance contract. The insurance contract is held by the Group Policyholder. You may request to inspect it at the Policyholder's main office during usual business hours. **READ YOUR CERTIFICATE CAREFULLY**

Signed for Amalgamated Life Insurance Company on the Date of Issue.

David J. Walsh

President

Group Level Term Life Insurance
Certificate
Non-Participating

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SCHEDULE OF INSURANCE

CERTIFICATE HOLDER [John Doe]

DATE OF BIRTH [x/xx/xxxx]

CERTIFICATE NUMBER [Specimen 123]

GROUP POLICY NUMBER [123]

GROUP POLICYHOLDER [Union ABC]

CERTIFICATE EFFECTIVE DATE [2/1/2009]

BENEFICIARY Mary Doe, Wife]

INSURED DEPENDENTS

[Mary Doe, Wife] DATE OF BIRTH [1/1/79] Age [30] [Lucy Doe, Child] Limiting Age [21]

DEATH BENEFIT [\$30,000] if Age at beginning of year is not over 64 [\$19,500] if age at beginning of year is 65 – 69

None of age at beginning of year is 70 or more

SCHEDULE OF [WEEKLY] PREMIUMS:

[Weekly] Premium	Age at Beginning of Year	[Weekly] Premium	Age at Beginning of Year	[Weekly] Premium	Age at Beginning of Year
[\$6.00] [6.00] [6.00] [6.00]	55 56 57 58 59	[\$2.10] [2.10] [2.10] [2.10] [2.10]	40 41 42 43 44	[\$1.50]	Under 30
[9.90] [9.90] [9.90] [9.90]	60 61 62 63 64	[2.70] [2.70] [2.70] [2.70] [2.70]	45 46 47 48 49	[1.50] [1.50] [1.50] [1.50] [1.50]	30 31 32 33 34
[10.14] [10.14] [10.14] [10.14] [10.14]	65 66 67 68 69	[3.90] [3.90] [3.90] [3.90] [3.90]	50 51 52 53 54	[1.80] [1.80] [1.80] [1.80]	35 36 37 38 39

SPOUSE [\$3,000] if Age at Beginning of Year is not over 64

DEATH BENEFIT [\$1,950] if Age at Beginning of Year is 65 to 69

None if Age at Beginning of Year is 70 or more

SCI Age at	HEDULE OF	[WEEKLY] PR	EMIUMS -	SPOUSE (if I	nsured)
Beginning of Year	[Weekly] Premium	Beginning of Year	[Weekly] Premium	Beginning	[Weekly] Premium
Under 30 30 to 34 35 to 40 40 to 44	[\$.15] [.15] [.18] [.21]	50 51 52 53 54	[\$.39] [.39] [.39] [.39]	60 61 62 63 64	[\$.99] [.99] [.99] [.99]
45 46 47 48 49	[.27] [.27] [.27] [.27]	55 56 57 58 59	[.60] [.60] [.60] [.60]	65 66 67 68 69	[1.01] [1.01] [1.01] [1.01] [1.01]

[CHILD [\$500] if Age at Death is less than 6 months
DEATH BENEFIT [\$4,000] if Age at Death is 6 months to 21 years
(if Insured) None if Age at Death is 22 years or more

SCHEDULE OF [WEEKLY] PREMIUMS - CHILDREN (if Insured) [\$.20]if any children Insured]

DEFINITIONS

"We", "us", "our" and "Company" means Amalgamated Life Insurance Company at our Home Office at 333 Westchester Avenue, White Plains, NY 10604.

"You", "your" means the Certificate Holder shown in the Schedule of Insurance.

"Policyholder" means the Group Policyholder shown in the Policy Schedule.

"Laid off" means you are not working because your employer has stopped providing work for you, and you are not being paid by any employer.

Disabled" means you are not working and are not able to do work of any. kind for wage or profit.

"Age" means the number of whole years since birth, or number of whole months for children under 1 year. Age at the beginning of the year means age of the person insured on January 1 of the calendar year.

DEATH BENEFIT

If you die while this Certificate is in force, we will pay the Death Benefit to the Beneficiary, subject to the terms of the group policy. We must receive due proof of your death at our Home Office. The amount of the Death Benefit is shown in the Schedule of Insurance. It is based on your age when you die.

If an Insured Dependent dies while insured under this Certificate, we will pay the Death Benefit to you, subject to the terms of the group policy. We must receive due proof of death at our Home Office. The amount of the Death Benefit is shown on the Schedule of Insurance. It is based on the age of your dependent at death.

MISSTATEMENT OF AGE or SEX

If the age or date of birth of an insured person shown in the Schedule of Insurance is not right, the Benefit paid at death will be based on the correct age or date of birth of such insured. If the benefit based on the correct age is zero, a refund of premium will be made. The amount of the refund will be the premiums paid to us since the benefit became zero.

INSURED DEPENDENT

For your spouse to be an Insured Dependent, we must have received a completed Enrollment Form signed by you that asks for insurance for your spouse. For your natural or legally adopted child to be an Insured Dependent, we must have received a completed Enrollment Form signed by you that asks for insurance for your children.

For a person to be an Insured Dependent at any time:

- (a) he or she must be an eligible dependent under the terms of the group policy.
- (b) you must not have revoked your payroll deduction authorization, and
- (c) you must still be insured under this Certificate.

You may enroll your dependents at any time, subject to the terms of the group policy. We may ask questions about their health when you enroll them, and we may refuse to insure one or more of them based on their health. You do not have to submit a new Enrollment Form for your natural child who is born alive while any of your children is an Insured Dependent. The new child will be an Insured Dependent at no extra cost if the above conditions are met. You do have to submit a new Enrollment Form for your newly adopted children if you want them to be Insured Dependents.

BENEFICIARY

The Beneficiary is the person to whom the death benefit is payable upon your death. The Beneficiary is named in the Enrollment Form for this insurance. You may change the Beneficiary at any time. You must do this in writing and you must date and sign the form. The change will take effect when we receive it.

If you name more than one Beneficiary, the Beneficiaries who survive you will receive the Benefit in equal shares unless you specify other shares. If no Beneficiary is alive when you die, the Benefit will be paid to the surviving person or persons first named in these classes:

- (a) your spouse;
- (b) your children, equally;
- (c) your parents, equally;
- (d) your brothers and sisters, equally;
- (e) your estate.

WHEN YOUR INSURANCE ENDS

Except as provided under Conversion, your insurance under this Certificate will end at the earlier of:

- (a) if you are laid off or disabled, [91 days] from the last day you worked;
- (b) if you are no longer employed by the Group Policyholder, and are not laid off or disabled, [31 days] from the last day you worked;
- (c) if you cancel your insurance by revoking your payroll deduction authorization, [31 days] from the end of the last payroll period for which deductions were made;
- (d) if premiums are not sent to us by the Group Policyholder, [31 days] from the last day of the last pay period for which we received premiums;
- (e) if you die, the date of your death;
- (f) if the group insurance policy terminates, on the day the group policy terminates.

You do not have to pay premiums while you are laid off or disabled.

CONVERSION

You may buy a new policy if your insurance ends because

- (a) you are no longer employed by the Group Policyholder, or
- (b) because the group insurance policy terminates.

The new policy may be on your life, but you may also buy a new policy on each of your Insured Dependents. Your spouse may buy a new policy if you die or if your marriage ends by divorce or annulment. It may be on his or her life if he or she was an Insured Dependent, but a new policy may also be bought on each child who was an Insured Dependent. Each child who is an Insured Dependent may buy a new policy on his or her life if the child's insurance ends when the child reaches the limiting age shown in the Schedule of Insurance.

Each new policy will provide life insurance only. It will be on one of the forms, other than term insurance, usually issued by us to individuals. The person who buys the converted policy may choose to have it preceded by term insurance for not more than one year with premiums payable at the same frequency as for the converted policy. The amount of insurance will be not less than \$500 and not more than the Benefit for the person under this certificate when *your* insurance ended. The premium for the new policy will be at our usual rates for the class of risk to which the person belongs.

You may buy a new policy on your life if the following conditions are met:

- (a) you are over age 60
- (b) the reduction in the benefit amount exceeds 20% of the initial benefit amount. The initial amount is the amount of benefit at the later of your age 60, or your age when this certificate was issued. The reduction amount is the difference between the initial amount and your current benefit.

The amount of insurance may not exceed the reduction amount.

To exercise the right to convert, a person must submit to us an application for a new policy and pay the first premium. If the person is notified of the right to convert within 15 days before or after the event that creates the right to convert, this must be done within 31 days of the event. Then the new policy will take effect 31 days after the event. If the person is not notified in that period, the time to apply to us is extended to the earlier of 45 days after notice is given or 90 days after the event. Then the new policy will take effect on the later of 31 days after the event or when the first premium is paid. If the person on whose life insurance may be purchased dies within 31 days after the event, we will pay, in accord with the terms of this policy, the amount of life insurance that could have been converted. In no case will the new policy take effect before the end of the period for which insurance is provided under the "When Insurance Ends" provision.

THE CONTRACT

This Certificate is not a contract. It is a statement of the coverage provided by the Group Policy. The provisions of the Group Policy that apply to you are shown in this Certificate. The entire contract is made up of the policy, the application for the policy, the certificate of insurance, any enrollment form completed by you or an insured dependent, copies of which are attached. Statements made by you or any insured dependent will be deemed representations and not warranties. No statement may be used to defend against a claim or to deny a claim under it, unless the statement is contained in the written application.

No one can change the terms of the contract unless the change is agreed to in writing and signed by one of our officers. We can change the premiums for this Certificate under the terms of the Group Policy. Other than that, once a person is insured under this Certificate, the premium and the Schedule for that person will not be changed as long as the group insurance policy and this certificate are continuously in force.

INCONTESTABILITY

Statements you make about any person insured under this Certificate will not be used to contest the insurance on that person:

- (a) unless it is in writing and a copy is given to you or your Beneficiary, or
- (b) after insurance on the person has been in effect for two years during the life of that person.

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604 Telephone: 1-800 315 9178

Endorsements, If any

Group Level Term Life Insurance
Certificate
Non-Participating

Rider attached to and forming a part of the Policy issued by Amalgamated Life Insurance Company. Effective as of the Effective Date shown in the Policy/Certificate.

ENDORSEMENT

This endorsement forms part of the Group Insurance Policy to which it is attached. The Group Policy, and any certificates issued under it, are amended as follows:

The second paragraph of the "Changes in the Policy" provision is deleted in its entirety and replaced by the following:

"We may change premiums and/or schedules of benefits by notice to you at least 30 days before the change takes effect. Any change, other than a change in premiums, will not apply to any persons insured prior to the change as long as this Policy and any relevant Certificates of Insurance are continuously in force. We will issue a revised Certificate of Insurance Schedule to show any new premiums for persons insured prior to the change. You will give the revised Certificate of Insurance Schedules to the Certificate Holders."

Signed for the Company on its issue date

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David J. Walsh President

AMALGAMATED LIFE INSURANCE COMPANY 333 Westchester Avenue White Plains, New York 10604

Living Benefit Rider

Amalgamated Life Insurance Company ("we", "us" "our) has issued this Rider as part of the policy/certificate to which it is attached. The effective date of this Rider is [the Certificate Date shown in the Certificate Schedule/ the Effective Date shown in the Notification of Certificate Change Endorsement]. Except as shown in this Rider, the provisions of the policy and your Certificate will prevail. **PLEASE READ THIS RIDER CAREFULLY**

BENEFIT

In consideration of the premium paid for this rider, the Insured may accelerate up to [25% to 50%] of the Certificate Death Benefit scheduled to be in effect one year from the date this benefit is requested. The Insured, Insured Spouse or Insured Dependent Child named in the Certificate must be diagnosed with a terminal condition, a critical illness [or is confined to a hospital] as defined below. We will pay the benefit if all requirements of this Rider are met.

The Accelerated Benefit, less any administrative charge, will be paid in a lump sum. Any remaining death benefit under the Certificate will be reduced by the amount of Accelerated Benefit. The amount of any accidental death benefit will not be affected by the payment of the accelerated benefit. Premium must continue to be paid for the Insured under the group policy after payment of an Accelerated Benefit in order to keep the remaining Certificate Death Benefit in force.

Receipt of Accelerated Benefits may affect eligibility for public assistance programs and may be taxable. Please consult a personal tax advisor to determine the tax status of any benefits paid under this rider.

DEFINITIONS

Accelerated Death Benefit: The amount payable by us to the Insured under this Rider.

Certificate Death Benefit: The amount shown on the Certificate of Insurance reduced by the amount of any Accelerated Death Benefit paid.

Insured: [The Individual named as the Insured in the Certificate. The Insured is also the Certificate Holder.]

Insured Spouse – The insured's spouse covered under the certificate of insurance

Dependent Child – The Insured's dependent child covered under the certificate of insurance.

[Eligibility: The Individual named as the Insured in the Certificate who is less than [65] years old and is actively at work.]

Administrative Charge: The amount of Accelerated Benefit is reduced as a result of the administrative cost to us to process the claim. The administrative charge shall be [\$75].

Physician: A Physician is a licensed medical doctor (M.D.) or doctor of osteopathy (D.O.) A Physician does not include the Insured, any person who lives with the Insured or a spouse, child, parent, brother, sister, grandparent, grandchild, or spouse of such relative of the Insured or Insured's spouse.

TERMINAL CONDITION

A condition caused by sickness or accident which, in the judgment of a Physician and subject to the approval of the Company, will directly result in a life expectancy of twelve months or less.

We may require examination of an insured. It will be at our expense by a licensed Physician chosen by us. If there is a discrepancy between two medical opinions, the opinion of our Physician will govern.

COVERED CRITICAL ILLNESS

A covered critical illness is cancer, heart attack, stroke, end stage renal disease, major organ transplant, paralysis or coma as defined in this Rider.

Cancer

[Cancer means an invasive malignancy which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also means in situ breast cancer.

Cancers not covered by this definition include:

- 1. Stage A prostate cancer.
- 2. Pre-malignant lesions, benign tumors or polyps.
- 3. Carcinoma in situ, except for in situ breast cancer.
- 4. Any skin cancer, except invasive malignant melanoma into the dermis or deeper.]

[Cancer shall mean the diagnosis of a malignancy, which is characterized by the uncontrolled growth of cancer cells with invasion of tissue.

Cancers not covered by this definition include:

- 1. Early prostate cancer, diagnosed as T1A NO MO and T1B NO MO or equivalent staging.
- 2. Non-invasive cancer in situ.
- 3. Pre-malignant lesions, benign tumors or polyps.
- 4. Any tumor in the presence of any Human Immunodeficiency Virus (HIV).
- 5. Any skin cancer other than invasive malignant melanoma greater than 0.75mm.

There shall be no coverage if within 90 days following the later of the issue date and the date of the last reinstatement of the policy, if

- 1. a diagnosis of cancer is made: or
- 2. any symptoms or medical problems commenced and initiated investigations leading to the diagnosis of any cancer.]

Heart Attack

[Heart Attack means the death of a portion of heart muscle resulting from a blockage of one or more coronary arteries. The diagnosis is based on an event that consists of all of the following:

- 1. chest pain;
- new electrocardiographic (EKG) changes consisting of new Q waves and localized T wave inversions;
- 3. elevation of cardiac (heart) enzymes.]

[Heart Attack means the death of a portion of the heart muscle, resulting from the blockage of one or more coronary arteries due to atherosclerotic heart disease.

The diagnosis must be based on all of the following criteria occurring at the same time:

- 1. new episode of typical chest pain or equivalent symptoms;
- 2. new electrocardiographic (ECG) changes indicative of an acute myocardial infarction; and
- 3. biochemical evidence of myocardial necrosis (heart muscle death) including elevated cardiac enzymes and/or troponin.

Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are specifically excluded.]

Stroke

[Stroke means a cerebrovascular accident caused by infarction of brain tissue, hemorrhage or embolism, resulting in measurable neurological deficit persisting for at least 30 days following the occurrence of the stroke. Stroke does not include Transient Ischemic Attack (TIA).]

[Stroke means a cerebrovascular accident diagnosed, unequivocally by a Neurologist licensed and practicing in the United States, as the death of brain tissue caused by thrombosis, hemorrhage or embolism. The diagnosis must be based on ALL of the following:

- 1. Sudden onset of new neurological symptoms.
- 2. New objective neurological deficits on clinical examination persisting continuously for at least sixty (60) days following the diagnosis of the stroke.
- 3. New findings on CT scan or MRI, if done, consistent with the clinical diagnosis.

Stroke does not include Transient Ischemic Attack (TIA).]

End Stage Renal Disease

[End State Renal Disease means a permanent failure of both kidneys from any cause that necessitates treatment by dialysis or kidney transplantation.]

[End State Renal Disease means kidney failure diagnosed with irreversible failure of both kidneys which necessitates treatment by regular dialysis or kidney transplantation.]

Major Organ Transplantation

[Major Organ Transplantation means the receipt by transplant of any of the following human organs or tissues:

- 1. Heart.
- 2. Liver.
- 3. Lung.
- 4. Kidney.
- 5. Bone Marrow.]

[Major Organ Transplantation means the undergoing of surgery, as a recipient by transplant of any of the following organs or tissues: heart, liver, lung, kidney or bone marrow.]

Paralysis

[Paralysis means a total irreversible loss of muscle function or sensation to the whole of any two limbs as a result of injury or disease. The paralysis must be permanent and supported by appropriate neurological evidence.]

[Paralysis means a complete and permanent loss of the use of two or more limbs, for a continuous period of 180 days, diagnosed by a Physician licensed and practicing in the United States.]

Coma

[Coma means a state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for a period of at least 96 hours and resulting in permanent neurological deficit. Coma secondary to alcohol or drug abuse is not covered.]

[Coma means a state of unconsciousness diagnosed with no reaction to external stimuli, for a continuous period of at least 96 hours. This Diagnosis must be made by a Neurologist licensed and practicing in the United States.]

[HOSPITAL CONFINEMENT

Hospital confinement requires that a covered individual be confined for 30 consecutive days. Confinement must be for reasons that are medically necessary and does not include confinement due to mental illness or substance abuse. A Physician must prescribe the hospital confinement. A signed written notice from the hospital is required to be submitted to Us. The written notice must include the dates of confinement and a

certification from the attending physician indicating the diagnosis of a medical condition requiring extraordinary medical care.]

[RESTORATION OF GROUP TERM INSURANCE BENEFIT

If after two years of receiving an accelerated benefit;

- 1. the Insured returns to work on a fulltime basis; and
- 2. the premiums to continue the group term insurance coverage have been paid;

the full amount of the Certificate Death Benefit in effect on the date the accelerated payment was requested will be reinstated.

Reinstatement of the Certificate Death Benefit does not apply to the Insured's Spouse or Insured Dependent Child.]

GENERAL

Incontestability. This Rider will not be contested after it has been in force during the lifetime of the Insured for two years from its effective date.

TERMINATION OF COVERAGE

Coverage under this Rider will end on the earliest of the following events to occur-

- 1. Upon written request to cancel it by the group policyholder;
- 2. Upon termination of the group policy;
- 3. Upon termination of the group certificate;
- 4. When the Insured is no longer a member of an eligible class of insureds under the policy;
- 5. The date of the Insured's death;
- 6. Upon payment of the Accelerated Death Benefit;
- 7. The date the Insured turns age 65.

EXCEPTIONS AND LIMITATIONS

[The benefit provided by this Rider is not meant to cause the Insured to involuntarily invade life insurance proceeds ultimately payable to the named beneficiary. The accelerated benefit will be made available on a voluntary basis only. Therefore, if it is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, the applicant is not eligible for this benefit. Or, if required by a government agency to use this option to apply for, obtain, or keep a government benefit or entitlement, the applicant is not eligible for this benefit.]

If the amount of term insurance in force on the Insured is scheduled to reduce because of an age related reduction, within one (1) year after the date this benefit is applied for, the maximum Accelerated Benefit will be limited to the scheduled reduced amount shown on the Certificate Schedule.

No accelerated benefit will be paid if:

- 1. The Insured made an absolute assignment or an irrevocable beneficiary designation of his/her group term life insurance, unless the absolute assignee or irrevocable beneficiary provides us with written consent to the acceleration;
- 2. The Insured's condition, illness or confinement resulted directly or indirectly from:
 - a. suicide or any self-inflicted injury, while sane or insane.
 - b. [use of illegal or illicit drugs or substances.]
 - c. [Misuse of drugs or alcohol.];

- 3. All or a portion of the Insured's life insurance benefits are paid as a part of a divorce settlement;
- 4. The required group life premium is due and unpaid.

TAX CONSIDERATIONS

This rider is intended to provide an Accelerated Death Benefit that qualifies as such under the Internal Revenue Code (IRC). Tax liability for any Accelerated Death Benefit payable under this rider may depend upon a number of factors including how the Internal Revenue Service interprets applicable provisions of the IRC. The Insured should consult a tax advisor to consider any tax consequences that may arise when benefits are paid under this rider.

OTHER FINANCIAL CONSIDERATIONS

Eligibility for public funds such as Medicare, Medicaid, Social Security, Supplemental Security Income (SSI), or other government assistance programs may be affected if the Insured receives benefits under this Rider.

President

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue, White Plains, New York 10604
Telephone: 1-800 315 9178

Amalgamated Life Insurance Company ("we", "us", "our") has issued this Rider as part of the Certificate to which it is attached. The effective date of this Rider is shown in the Rider Schedule below. Except as shown in this Rider, the provisions of the Certificate will prevail. PLEASE READ THIS RIDER CAREFULLY.

Rider Schedule

CERTIFICATE HOLDER	[John Doe]
CERTIFICATE NUMBER	[12]
GROUP POLICY NUMBER	[GLT123]
GROUP POLICYHOLDER	[Union ABC]
RIDER EFFECTIVE DATE	[Jan 1, 2009]

SCHEDULE OF ADDITIONAL [WEEKLY] PREMIUMS FOR ACCIDENTAL DEATH BENEFIT

Age at Beginning of Year	[Weekly] Premium	Age at Beginning of Year	[weekly] Premium	Age at Beginning of Year	[Weekly] Premium
Under 35 35 to 39	[\$.48] [.48]	40 to 44 45 to 49 50 to 54	[\$.54] [.54] [.60]	55 to 59 60 to 64 65 to 69	[\$.66] [.84] [.74]

Additional weekly premiums for Accidental Death Benefit are based on your age.

ACCIDENTAL DEATH BENEFIT RIDER

We will pay an Accidental Death Benefit upon receipt of due proof of Accidental Death of you or, if an Insured Dependent at the time of death, your spouse. The Accidental Death must occur while this Rider is in force. The amount of the Accidental Death Benefit will be the same as the Death Benefit, and will be based on the age of the person who dies. The Accidental Death Benefit will be paid with, and in the same manner as, the Death Benefit. We will have the right and opportunity to examine the body of the dead person to make an autopsy unless forbidden by law. No Accidental Death Benefit will be paid at the death of an insured child.

ACCIDENTAL DEATH

Accidental Death means death resulting directly from accidental bodily injury. The death must be independent from all other causes. The death must occur within 180 days of the injury that causes it.

NOT COVERED

No benefits will be paid for death resulting from or caused directly or indirectly by:

- 1. War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion;
- 2. Sickness, disease or bodily infirmity. (This does not include bacterial infection which results from an accidental cut or wound or accidental ingestion of a poisonous food substance;
- 3. Taking a poison or asphyxiation from or inhaling of gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment;
- 4. Intentionally self inflicted injury, while sane or insane;
- 5. Suicide or attempted suicide, while sane or insane;
- 6. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers
- 7. Commission of or participation in a crime

START AND TERMINATION

This Rider shall not be in force until you have completed an enrollment form that asks for the Accidental Death Benefit and additional premium for the Accidental Death Benefit has been sent to us by the Group Policyholder. This Rider shall cease to be in force on the date your insurance under this certificate ends.

Signed for the Company on its date of issue:

-)] [Wahr

President

SERFF Tracking Number: AMAL-126333212 State: Arkansas
Filing Company: Amalgamated Life Insurance Company State Tracking Number: 44099

Company Tracking Number: ALGDTP-09

TOI: L04G Group Life - Term Sub-TOI: L04G.313 Decreasing - Single Life -

Fixed/Indeterminate Premium

Product Name: Workers Life Plus

Project Name/Number: Workers Life Plus/ALGDTP-09

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification

Comments:

This is the Flesch certification for all of the forms included in this filing.

Attachment:

Flesch certification.pdf

Item Status: Status

Date:

Satisfied - Item: Application

Comments:

These are the group application and two enrollment forms, one for the decreasing term version of the policy and the other for the level term version.

Attachments:

ALGA-09 Application for Group Insurance.pdf
ALGDTEF-09 (AR) Decreasing Term Enrollment Form - final.pdf
ALGLTEF-09 (AR) Level Term Enrollment Form - final.pdf

Item Status: Status

Date:

Satisfied - Item: Claim form, etc. for living benefit

rider

Comments:

These are the claim form, disclosure and generic illustration for the living benefit rider.

Attachments:

AMADB-AD-PLUS-01-FW-CLAIM FORM.pdf AMADBDIS-PLUS-01-DISCLOSURE.pdf

AMADBDIS2-PLUS-01-GENERIC ILLUSTRATION.pdf

AMALGAMATED LIFE INSURANCE COMPANY

CERTIFICATION

Amalgamated Life Insurance Company has reviewed the enclosed forms(s) and certifies that to the best of its knowledge and belief, the form(s) meet(s) the minimum flesch scale readability requirements of your State.

FORM	SCORE
ALGDTP-09	49.0
ALGDTC-09	62.4
ALGLTC-09	62.0
ALTLADBR-09	55.9
ALGDTP-END-09	46.6
ALGDTEF-09	45.8
ALGLTEF-09	45.8
ALGA-09	46.9
ALTLLBRC-07	46.1

Date: November 5, 2009

Assistant Vice President

Application for Group Insurance to: Amalgamated Life Insurance Company ("the Company") 333 Westchester Avenue, White Plains, NY 10604

		Policyholder ("the I	Policyholder")	
		Policyholder's	Address	
Applies for	the following insurance u	nder and in accordance w	rith the Group Policy:	
	Basic Term Life	□ Dependent Life	□ Supplemental Li	fe
	Voluntary Payroll Dedu	ction Life		
	Accidental Death			
	Accelerated Death			
	Other	(please specify)		
has been is	sued in replacement of the	ne coverages listed abov	e under:	
This contract	ct will be effective on			
	that this application take		d its terms have been accepted nary application which has bee	
			perience rating under this policy the Group Policy which is being	
Company; o		Company's rights or requ	rer: (i) to make or modify any co uirements. No waiver will be val	
Signature o	f Policyholder	<u> </u>	Date	
Printed Nan	ne & Title of Authorized S	Signer	Witness or Agent/Sales Repres	sentative
		RECEIF	PT	
for which ap	as a credit toward the pay	(Na yment of the first premiur e application is not acce	nme of Applicant) \$ m on the proposed Group Insura pted by Amalgamated Life, the	to be to ance Policy, or Policies payment evidenced by
Date		Age	ent or Representative	

Amalgamated Life

Enrollment Form - Payroll Deduction Authorization

Complete and sign both sides of this form and mail to: Amalgamated Life Insurance Company, Policy Services, 333 Westchester Avenue, White Plains, NY 10604

PLEASE PRINT MIDDLE NAME **ADDRESS** CITY STATE 7IP SOCIAL SECURITY NUMBER __ (CHECK ONE) MALE FEMALE DATE OF BIRTH MONTH **Employment Information** EMPLOYER NAME HAVE YOU BEEN ACTIVELY AT WORK FOR 60 DAYS OR MORE? YES NO 3. DATE OF HIRE Choose Your Coverage Option CHECK THE APPROPRIATE BOXES, YOUR EMPLOYER WILL DEDUCT FOR THE COVERAGE YOU SELECT. Workers Life Decreasing Term Benefit: Deduction Frequency ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ Other ___ Coverage for you Weekly Premium a. LIFE INSURANCE ONLY [\$2.00] 2 Coverage for your spouse □ [\$.45] 3 Coverage for your child(ren) **[**\$.20] LIFE INSURANCE with Accelerated Death Benefit Rider..... TOTAL DEDUCTION Spouse Information NAME OF WIFE OR HUSBAND _ MIDDLE AGE SOCIAL SECURITY NUMBER _ DATE OF BIRTH MONTH YEAR **Beneficiary Information** AGE _____ RELATIONSHIP _ (WIFE, FRIEND, SON, ETC.) FIRST MIDDLE IF YOU HAVE MORE THAN ONE BENEFICIARY, LIST NAMES, ADDRESSES AND RELATIONSHIPS ON A SEPARATE SHEET OF PAPER, DATE AND SIGN AND ATTACH TO ENROLLMENT FORM. YOU MAY CHANGE YOUR BENEFICIARY, AT ANY TIME, BY NOTICE TO THE COMPANY. Health Questions please respond "yes" or "no" to the following questions. Note that your spouse must also answer these QUESTIONS, AND SIGN ON THE REVERSE SIDE, IF SPOUSE COVERAGE IS SELECTED. **EMPLOYEE SPOUSE** HAVE YOU CONSULTED OR BEEN ATTENDED BY A PHYSICIAN OR BEEN A PATIENT IN ANY HOSPITAL DURING THE PAST ☐ YES ☐ YES TEN YEARS? Пио □ NO REASON HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR AIDS OR AIDS RELATED CONDITIONS? ☐ YES ☐ YES □ NO TO THE BEST OF YOUR KNOWLEDGE, ARE YOU IN GOOD HEALTH AND FREE FROM THE EFFECTS OF ANY OTHER ILLNESS OR DISEASE, INJURY, OR ALCOHOL OR DRUG ABUSE OR OTHER ADDICTION? ☐ YES ☐ YES IF "NO", EXPLAIN: EMPLOYEE __ Пио SPOUSE HEIGHT AND WEIGHT HT ____ WT_ I ENROLL IN THE WORKERS LIFE BENEFITS PLAN AND AUTHORIZE PAYROLL DEDUCTIONS TO PAY FOR IT. I AM AN ELIGIBLE EMPLOYEE, ACTIVELY AT WORK ON THE DATE I SIGNED THIS FORM, I MAY REVOKE THIS AUTHORIZATION FOR PAYROLL DEDUCTION AT ANY TIME BY WRITTEN NOTICE TO MY EMPLOYER. **Employee** Home

PLEASE COMPLETE THE REVERSE SIDE

Phone _____

Signature X

AUTHORIZATION: I hereby authorize any insurance company or the Medical Information Bureau that has any records or knowledge of me or my health, to give to the Amalgamated Life Insurance Company, or its reinsurers, any such information for determining my eligibility for coverage. I agree that this authorization shall remain valid for three (3) years from the date indicated below and that a photographic copy of this authorization shall be as valid as the original. The undersigned acknowledges receipt of the Medical Information Bureau.

I understand that this coverage shall become effective only if this application is accepted by the Company.

The company reserves the right to require additional information as part of this application. I represent that to the best of my knowledge and belief all statements and answers recorded on this application are true and correct.

I understand that this application and any coverage resulting from it can be voided if I have intentionally or unintentionally misrepresented a material fact in answering any of the questions on this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature	x	Date Signed
Spouse Signature	X	Date Signed

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We will not procure or cause to be prepared any investigative consumer report on your insurability. We or our reinsurers may, however, make a brief report to the Medical Information Bureau based strictly on information on the application and/or the enrollment form. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense of created by those who would conceal facts relevant to their insurability. If you apply to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon

request, will furnish that company with information about you from its files. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Upon request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the bureau's files, you may seek correction from the Bureau. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617-426-3660.



333 Westchester Avenue • White Plains, NY 10604 914-367-5000

America's Labor Insurance Company®

Amalgamated Life

Enrollment Form - Payroll Deduction AuthorizationComplete and sign both sides of this form and mail to: Amalgamated Life Insurance Company, Policy Services, 333 Westchester Avenue, White Plains, NY 10604

PLEASE PRINT			
NAME LAST	FIRST	MIDD	LE
ADDRESS			
CITY STATE			ZIP
SOCIAL SECURITY NUMBER		(CHECK O	NE)
DATE OF BIRTH		☐ MALE	FEMALE
MONTH DAY YEAR	AGE		
Employment Information 1. EMPLOYER NAME		Account #	
2. HAVE YOU BEEN ACTIVELY AT WORK FOR 60 DAYS OR MORE? YES	NO 3. DATE OF HIRE	MONTH	YEAR
Choose Your Coverage Option CHECK THE APPROPRIATE Workers Life Level Benefit: Deduction Frequency week!			
Coverage for you a. LIFE INSURANCE ONLY b. LIFE INSURANCE with Accelerated Death Benefit Rider	Face Amount Weekly Premium		
Coverage for your spouse a. LIFE INSURANCE ONLY	Face Amount Weekly Premium		
Coverage for your child(ren) a. LIFE INSURANCE ONLY	Face Amount Weekly Premium		
Spouse Information NAME OF WIFE OR HUSBAND			
SOCIAL SECURITY NUMBER	FIRST DATE (MIDD OF BIRTH	LE AGE
			DAY YEAR
Beneficiary Information			
NAMELAST FIRST MIDDLE	AGE RELATIONSHIP	(WIFE, FRIEND,	SON, ETC.)
ADDRESS			_
IF YOU HAVE MORE THAN ONE BENEFICIARY, LIST NAMES, ADDRESSES AND RELA ENROLLMENT FORM. YOU MAY CHANGE YOUR BENEFICIARY, AT ANY TIME, BY NO		OF PAPER, DATE AND SIGN	AND ATTACH TO
Health Questions PLEASE RESPOND "YES" OR "NO" TO THE FOLI		JR SPOUSE MUST ALSO AN	ISWER THESE
QUESTIONS, AND SIGN ON THE REVERSE SIDE, IF SPOUSE COVERAGE IS SELECT	ED.	EMPLOYEE	SPOUSE
 HAVE YOU CONSULTED OR BEEN ATTENDED BY A PHYSICIAN OR BEEN A PA TEN YEARS? 	TIENT IN ANY HOSPITAL DURING THE	PAST YES	☐ YES
REASON		□ NO	□NO
2a. HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR AIDS OR AIDS RELATED CONDITIONS?			
		☐ YES	☐ YES
2b. TO THE BEST OF YOUR KNOWLEDGE, ARE YOU IN GOOD HEALTH AND FREE FROM THE EFFECT ALCOHOL OR DRUG ABUSE OR OTHER ADDICTION?	CTS OF ANY OTHER ILLNESS OR DISEASE, INJ	□ NO URY, OR	□NO
IF "NO", EXPLAIN:		☐ YES	∏ YES
(EMPLOYEE) (SPOUSE)		— □ NO	□ NO
		_ -	
3. HEIGHT AND WEIGHT		HT WT	
I ENROLL IN THE WORKERS LIFE BENEFITS PLAN AND AUTHORIZ EMPLOYEE, ACTIVELY AT WORK ON THE DATE I SIGNED THIS FOI			
DEDUCTION AT ANY TIME BY WRITTEN NOTICE TO MY EMPLOYER			

Date _

Home

Phone ___

Employee

Signature X

AUTHORIZATION: I hereby authorize any insurance company or the Medical Information Bureau that has any records or knowledge of me or my health, to give to the Amalgamated Life Insurance Company, or its reinsurers, any such information for determining my eligibility for coverage. I agree that this authorization shall remain valid for three (3) years from the date indicated below and that a photographic copy of this authorization shall be as valid as the original. The undersigned acknowledges receipt of the Medical Information Bureau.

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I understand that this application and any coverage resulting from it can be voided if I have intentionally or unintentionally misrepresented a material fact in answering any of the questions on this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature	X	Date Signed
Spouse		Date
Signature	X	Signed

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We will not procure or cause to be prepared any investigative consumer report on your insurability. We or our reinsurers may, however, make a brief report to the Medical Information Bureau based strictly on information on the application and/or the enrollment form. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense of created by those who would conceal facts relevant to their insurability. If you apply to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon

request, will furnish that company with information about you from its files. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Upon request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the bureau's files, you may seek correction from the Bureau. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617-426-3660.



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America's Labor Insurance Company®

AMALGAMATED LIFE INSURANCE COMPANY 333 Westchester Ave., White Plains, NY 10604

Accelerated Benefit Claim Form

All Requested Information Must Be Provided

Transmittal Date_____

Section I	To Be Completed by Member/Employee or Legal Representative						
Insured's Name	Address			Amount of Accelerated Benefit			
Social Security No.	Telephone No.	Date of Birth		Sex M	M	F	Remaining Death Benefit
Occupation			Date Condition	was First	t Ide	ntified	
Condition Contributing to Your N	leed for Accelerated Benefits	What Impor	tant Daily Duties	s Are You	ı Un	able to Pe	erform?
When Do You Expect to Resume	The Majority of Your Duties?	<u> </u>					
If You Are Currently In A Location	on Other Than Your Home, Please	Provide Complete N	lame and Addres	ss:			
Type of Place (Relative's Home,	Home, Hospital, Nursing Home, etc.) Telephone No.						
Section II	To Be Completed by Employer						
Employer/Group Name							
Address							
Insured's Annual Basic Earnings	Amoun	t of Insurance	Date	Employed	d		
Is Insured Still Working?	If Not, Date Last Worked						
If Insured Was Terminated, Please Specify Reason For Termination:							
Illness	Retired	Resigned		Oti	ther		

Section III Disclosures and Authorizations

- 1. Receipt of Accelerated Benefits may effect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Prior to applying for Accelerated Benefits, the Insured or their Authorized Representative should consult with the appropriate social services agency concerning how receipt will affect eligibility of the recipient and/or their spouse or dependents.
- 2. Receipt of Accelerated Benefits may be taxable. Prior to applying for such benefits the Insured should seek assistance from a qualified tax advisor.
- 3. This request for Accelerated Benefits is voluntary and without coercion on the part of any third party.
- 4. No healthcare facility as defined in Section 20 of the Public Health Law can require the Insured to accelerate payment of death benefits as a condition of admission or for providing care in any such facility.
- 5. The Remaining Death Benefit available to the Insured is set forth in Section I of this claim form. The Company will issue an amended schedule page to the Insured that will reflect the reduced face amount of death benefit available after payment of the Accelerated Benefit.
- 6. The company is prohibited from paying an Accelerated Benefit for a period of 14 days from the date on which the information under Section 41.4(e) of Regulation 143 is transmitted to the Insured.
- 7. This Claim Form must be completed and signed by the Insured not more than 30 days after the Transmittal Date on page 1 of this form.
- 8. The Company will provide, pursuant to Section 41.4(e) of Regulation 143, within 5 days after receipt of this form, a numerical computation of the effect on the Insured's death benefit with and without payment of an Accelerated Benefit and other related information.
- 9. The Insured acknowledges the Administrative Charge of [\$75] will reduce the amount of any Accelerated Benefit paid.

I hereby authorize any hospital, healthcare facility, physician, surgeon or other healthcare professional to provide its agents or employees, or independent administrators acting on its behalf, information pertaining to any examination or treatment furnished to the above named patient or for any illness, injury or any condition the patient has had at any time in the past or may continue to have in the future up to the expiration of this authorization. I understand this information is collected in connection with claims for insurance benefits and to determine eligibility for benefits. This authorization is valid for the term of coverage of the policy. A photocopy of this authorization is as valid as the original. The Insured or the authorized Representative is entitled to receive a copy of this form.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Insured's Signature or	Date
Legal Representative's Signature	

AMALGAMATED LIFE INSURANCE COMPANY 333 Westchester Avenue White Plains, NY 10604

DISCLOSURE REGARDING ACCELERATED BENEFIT OPTION (Required under Section 41.4(e) of Regulation 143.)

Insured	
Certificate Number	
Group Policy Number	
Date of Request for Accelerated Benefit	
Death Benefit	
Accelerated Benefit Payable with	Benefit Acceleration
1. Amount of Accelerated Benefit – [50%] of Death Bene	fit \$
2. Administrative Charge	\$
3. Amount Payable for Accelerated Benefit	\$
4. Remaining Death Benefit	\$
Death Benefit Payable without Be	<u> </u>
Date B	v

AMALGAMATED LIFE INSURANCE COMPANY 333 Westchester Avenue White Plains, NY 10604

GENERIC ILLUSTRATION OF BENEFIT UNDER ACCELERATED BENEFIT RIDER

Insured John Doe

Certificate Number 1234

Group Policy Number 6789

Death Benefit \$5,000

Accelerated Benefit Available Under Rider: [50%] of Death Benefit

Qualifying Events for Payment of Accelerated Benefit: When the Insured has a terminal condition (or a covered critical illness or is in a covered hospital confinement) as defined in the rider attached to the Insured's certificate of insurance

Accelerated Benefit Payable with Benefit Acceleration

1. Amount of Accelerated Benefit \$2,500

2. Administrative Charge \$ 75

3. Amount Payable in Cash \$2,425

4. Remaining Death Benefit \$2,500

Death Benefit Payable without Benefit Acceleration

\$5,000

Date: 2/2/2007 By: Jean Jones